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No. 02-1845

IN THE

Supreme Court of the United States

AETNA HEALTH INC.,

Petitioner,

v.

JUAN DAVILA,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

MOTION FOR LEAVE TO FILE BRIEF AND BRIEF OF THE AMERICAN ASSOCIATION OF HEALTH PLANS, INC., THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA, THE AMERICAN BENEFITS COUNCIL AND THE NATIONAL ASSOCIATION OF MANUFACTURERS AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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Pursuant to Rule 37.2 of the Rules of this Court, the American Association of Health Plans, Inc. ("AAHP"), the Chamber of Commerce of the United States of America (the "Chamber"), the American Benefits Council (the "Council") and the National Association of Manufacturers (the "NAM") respectfully move for leave to file the attached brief as *amici curiae* in support of Petitioner. Petitioner has consented to the filing of this brief. Its letter of consent has been lodged with the Clerk of the Court. Respondent has declined to consent.

The AAHP is the national association for the managed care community. AAHP's mission is to advance health care quality and affordability through leadership in the health care community, advocacy and the provision of services to member health plans. Its membership includes health maintenance organizations, preferred provider organizations, third party health plan administrators, health care utilization review organizations, prepaid limited health service plans, and other integrated health care delivery systems. AAHP represents more than 1,000 managed health care organizations serving nearly 160 million Americans, the majority of whom are participants or beneficiaries of employee benefit plans covered by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §1001, *et seq.*

The Chamber is the world's largest business federation, representing an underlying membership of over three million businesses and organizations of every size, in every industry sector, and from every geographic region of the country. A principal function of the Chamber is to represent the interests of its members by filing *amicus* briefs in cases involving issues of vital concern to the nation's business community. Many Chamber members provide health benefits to employees and arrange for the provision of health care services through employee welfare benefit plans regulated under ERISA. The ability of its members to purchase affordable health care coverage for the benefit of their employees is of vital importance to them, their employees, and the employees' dependents, and to the Chamber.

The Council is a broad-based, non-profit trade association founded in 1967 to protect and foster the growth of this nation's privately sponsored employee benefit plans. The Council's members include both small and large employer-sponsors of employee benefit plans, including many Fortune 500 companies. Its members also include employee benefit plan support organizations, such as actuarial and consulting firms, insurers, banks, investment firms, and other professional benefit organizations. Collectively, its more than 250 members sponsor and administer plans covering more than 100 million plan participants and beneficiaries.

The NAM is the nation's largest industrial trade association. The NAM represents 14,000 members (including 10,000 small and mid-sized companies) and 350 member associations serving manufacturers and employees in every industrial sector and all 50 states.

Amici file this brief because of their interest in preserving the ability of the managed care community to arrange for quality, affordable health care, including prescription drug benefits, on behalf of ERISA-covered health plans. The Fifth Circuit's decision substantially increases the liability of persons that make benefit claims decisions, increasing health plan costs, thereby discouraging employers from providing prescription drug benefits and health plans to their employees.

For the foregoing reasons, AAHP, the Chamber, the Council and the NAM respectfully request that they be allowed to participate in this case by filing the attached brief.

Respectfully submitted,

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INTEREST OF *AMICI CURIAE*

The interest of *amici curiae*, AAHP, the Chamber, the Council and the NAM are set forth in the motion accompanying this brief.[1]

[1] Pursuant to Supreme Court Rule 37.6, *amici* state that no counsel for a party authored this brief in whole or in part and no person or entity other than *amici* contributed monetarily to the preparation and submission of this brief.

STATEMENT OF THE CASE

The *amici* incorporate the Statement of the Case in the Petition for Writ of Certiorari and briefly summarize the portions of the opinion of the United States Court of Appeals for the Fifth Circuit (App. 1a-29a) (*Davila*) relevant to their arguments.

Juan Davila's primary care physician prescribed the anti-inflammatory medication Vioxx for treatment of Davila's arthritis. However, the prescription drug formulary established as part of the health plan maintained by Davila's employer, Monitronics International, Inc., required that Davila obtain pre-certification prior to coverage of Vioxx.[2] The formulary provided coverage for similar, but less costly, medication without pre-certification.[3]

Aetna denied Davila's claim for Vioxx. Aetna provided notice that Davila's physician had not sought pre-certification, but that the plan would cover Vioxx if Davila's physician indicated that the less costly drug was contraindicated. The letter provided a list of alternative medications available under the plan's formulary without pre-certification, as well as the grievance and independent review procedures available to Davila. App. 80a-81a.

[2] The cost of prescription drugs has skyrocketed over the last several years. In 2001, prescription drug costs climbed 17 percent, contributing to a 13 percent increase in total health plan costs. *See* Howard Weiss, Prescription Drug Formularies: Ensuring Access to Safe and Effective Medications, HEALTHPLAN, November/December 2002 at 52. The vast majority of health plans make drug benefits available through a formulary, which is one means of controlling drug benefit costs. A formulary lists drugs that a plan will cover as a benefit. A formulary typically provides different co-payment amounts for different groups of covered drugs and excludes some drugs from coverage. Health plans commonly require pre-certification for certain drugs included in the formulary. At least thirty-nine states impose some formulary restrictions as part of their Medicaid programs. *See* Renee Schwalberg, *et al.*, Medicaid Outpatient Prescription Drug Benefits: Findings from a National Survey and Selected Case Study Highlights at 6-7 (2001).

[3] In 2000, 96% of private sector employees with employer-sponsored health coverage were enrolled in plans that included pre-certification or similar utilization review requirements. *See* Bureau of Labor Statistics, National Compensation Survey: Employee Benefits in Private Industry in the United States at 10-11, 29 (2003).

Under its contract with Monitronics, Aetna made final decisions with respect to claims for benefits under the plan. App. 102a.[4] However, Aetna did not provide medical services to Davila, nor did Aetna supervise or control the actions of treating physicians made available under the plan's preferred provider network. App. 98a.

Aetna's claims decision was comprehensively regulated by ERISA. Aetna was subject to ERISA's mandated claims procedure, which imposes notice and appeals requirements on group health plans. 29 U.S.C. § 1133; 29 C.F.R. § 2560.503-1. In making claims decisions, Aetna served as a fiduciary of the Monitronics plan. 29 U.S.C. § 1002(21)(A); *Reich v. Lancaster*, 55 F.3d 1034, 1047 (5th Cir. 1995); *Pacificare Inc. v. Martin*, 34 F.3d 834, 837 (9th Cir. 1994). As a fiduciary, Aetna was subject to ERISA's fiduciary duties of prudence and loyalty, as well as its prohibition against fiduciary self-dealing and kickbacks. 29 U.S.C. §§ 1104, 1106(b). ERISA's detailed remedial scheme provided plan participants—such as Davila—with a remedy for a denied benefit claim or a breach of fiduciary duty. 29 U.S.C. § 1132(a)(1)(B), (a)(2) & (a)(3).

[4] While policies issued by HMOs and insurance companies themselves do not constitute ERISA plans, such policies commonly set forth all or part of the terms of an employee benefit plan, including plan benefits. *Pegram v. Herdrich*, 530 U.S. 211, 223 (2000). When disputes arise over policy terms, however, plan participants must bring claims under ERISA to enforce the terms of the plan. *Plumb v. Fluid Pump Serv., Inc.*, 124 F.3d 849 (7th Cir. 1997).

Following notice of Aetna's claims decision, Davila failed to pursue his administrative remedy to appeal the decision as provided under ERISA section 503, and as set forth in Aetna's denial letter to him. Davila also failed to pursue review by an independent review organization as set forth in Aetna's letter. And Davila chose not to pursue his judicial remedy to sue for benefits under ERISA section 502(a)(1)(B). Instead, Davila later sought redress for Aetna's claims decision in Texas state court asserting that Aetna failed to exercise "ordinary care"—the standard negligence test—under the Texas Health Care Liability Act. App. at 69a.

Aetna removed Davila's action to the U.S. District Court for the Northern District of Texas, asserting that the claim was completely preempted by ERISA and removable under *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 64-66 (1987). The district court agreed, concluding that "distilled to its essence" Davila's claim "concerns the administration of benefits under the plan." App. at 34a.

The Fifth Circuit reversed. The court applied a self-described "narrow" test for complete preemption, concluding that ERISA section 502 preempts only those state law claims that "duplicate[]" a cause of action provided under ERISA section 502. *Id.* at 9a. Applying this test, the court found that Davila's tort claim did not encroach on ERISA's remedies since it did not duplicate the equitable claims authorized by section 502(a)(3), the fiduciary duty claims authorized by section 502(a)(2) or the contract claims authorized by section 502(a)(1)(B). *Id.* at 12a-20a.

The Fifth Circuit's test for complete preemption looked at whether the state law cause of action and form of relief sought by Davila were available under ERISA. Because tort claims for money damages are not available under ERISA, the court found that Davila's claims were not completely preempted.

REASONS FOR GRANTING THE PETITION

The Fifth Circuit's *Davila* decision threatens the foundation on which ERISA was built. Congress constructed ERISA taking into account the fact that employers voluntarily offer benefit programs to their employees and that the inherent costs of state by state regulation must be limited. In order to encourage employers to offer benefit plans, Congress included ERISA section 514, an express preemption provision, to foster uniform and lower cost regulation of multi-state benefit plans. Congress also adopted a detailed, but exclusive, remedy scheme under ERISA section 502, to ensure that plans were not subject to a costly patchwork of conflicting and open-ended state law remedies.

The Fifth Circuit mistakenly relies on dicta in this Court's *Pegram* decision to depart from an unbroken string of Supreme Court decisions holding that ERISA's remedies are exclusive. *Davila* leaves employers and labor unions who sponsor plans, and the insurers and third party administrators who act on their behalf, exposed to suits for compensatory and punitive damages under varying state laws for routine health plan claims decisions. All health plans will be affected—both insured and self-insured.

Davila will result in a patchwork of remedies that will expand liability and increase health plan costs. Routine plan provisions, such as pre-certification and drug formularies, will be compromised. Employers will be forced to take measures to restrict or eliminate prescription drug and other benefits to limit cost increases. Consumers and plan participants will pay the ultimate price—facing higher co-payments, deductibles and premiums, while being subject to restricted benefits and drug selection.

ERISA's remedy scheme reflects a careful balancing of interests that Congress made after a decade of study. Allowing states to supplement ERISA's remedy scheme with

tort claims with potentially unlimited money damages against claims administrators eviscerates the policy choices Congress is best suited to make.

I. THE COURT SHOULD GRANT THE PETITION TO CLARIFY ITS DECISION IN *PEGRAM V. HERDRICH* AND RESTORE UNIFORMITY AND EXCLUSIVITY TO ERISA'S REMEDY SCHEME FOR BENEFIT DISPUTES.

A. Uniformity in administration and remedies lowers administrative expenses and litigation costs and fosters America's voluntary employee benefits system.

Over 130 million Americans participate in group health plans governed by ERISA, all of which are voluntarily sponsored by employers and labor unions. *See "Small Business Health Fairness Act": Hearing on H.R. 660 Before the Subcom. on Employer-Employee Rel. of the House Comm. on Educ. & the Workforce*, 108th Cong. (Mar. 13, 2003) (statement of Ann L. Combs, Ass't Sec'y for Employee Benefits Sec., U.S. Dep't of Labor). ERISA reflects "competing congressional purposes, such as Congress's desire to offer employees enhanced protection for their benefits . . . and its desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place." *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996).

"One of the principal goals of ERISA is to enable employers 'to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits.'" *Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001) (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987)). Of course, providing for uniformity lowers plan administrative expenses and legal costs and encourages employers to voluntarily

sponsor group health plans. "Uniformity is impossible, however, if plans are subject to different legal obligations in different States." *Id.*

Providing an exclusive remedy for claims decisions is essential to fulfilling Congress's goal of controlling employer costs by promoting nationally uniform plan administration. This Court has made clear that was Congress's intent:

> The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive.

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54 (1987).

The Court has never deviated from its conviction that ERISA's remedies are exclusive. In *Taylor*, 481 U.S. 58, decided on the same day as *Pilot Life*, the Court held that a complaint filed in state court alleging, on its face, only state law causes of action was properly removable to federal court under the doctrine of "complete preemption." The *Taylor* decision rests on the same fundamental conclusion as *Pilot Life*—that ERISA's remedies are so comprehensive that Congress's intent to provide an exclusively federal set of remedies is manifest. *See also Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 143 (1990) (even without preemption under section 514(a), state law cause of action would be preempted because it conflicts with ERISA section 502).

The Court affirmed its view just recently in *Rush Prudential HMO v. Moran*, 536 U.S. 355 (2002). In *Rush*, the Court found that the Illinois independent review requirement, which it likened to a second medical opinion rather than an arbitration remedy, did not run afoul of ERISA's exclusive remedy scheme since the law "provides no new cause of action under state law and authorizes no new form of ultimate

relief." *Id.* at 379. Thus, an independent reviewer's decision would be enforceable in an action under ERISA section 502, *see Moran v. Rush Prudential*, 230 F.3d 959, 971 (7th Cir. 2000), and "[would] not enlarge the claim beyond the benefits available in any action under section 502(a)." 536 U.S. at 379.

The Fifth Circuit adopted a "narrow" view of the *Taylor* complete preemption doctrine, finding that ERISA section 502 preemption applies only when the state law cause of action *duplicates* one of ERISA's specific remedies. App. at 9a. The decision completely disregards this Court's decisions in *Pilot Life*, *Taylor* and *Ingersoll-Rand*, each of which addressed an underlying state tort claim that did not in any way duplicate any of the remedies in ERISA section 502. Plaintiffs will easily circumvent ERISA's remedies and federal jurisdiction by simply pleading state tort claims and avoiding state contract or equitable claims. The result will be to permit a "new cause of action under state law" providing "a new form of ultimate relief." *Rush*, 536 U.S. at 379. Indeed, that is precisely what happened in this case, with Davila asserting a cause of action for money damages under the Texas Health Care Liability Act, instead of pursuing the administrative and judicial remedies provided under ERISA.[5]

The Fifth Circuit's decision eviscerates Congress's overarching goal of limiting costs by promoting uniformity. *Davila* applies equally to insured and self-insured health plans. It applies to benefits available under a drug formulary, as well as any other plan benefits. If left intact, a fifty-state patchwork scheme of ERISA enforcement will apply to

[5] A number of states have adopted statutes similar to the Texas law, which are intended to provide remedies against HMOs and insurers for benefit claims denials. *See, e.g.*, Ga. Code Ann. §§ 51-1-48, 51-1-49; Me. Rev. Stat. Ann. tit. 24-A, § 4313. Moreover, state common law likely provides a remedy in those states that have not adopted a statutory remedy like the Texas law.

administrative decisions to pay or deny claims for benefits. Faced with different state liability rules, administrators will make conflicting decisions because of different remedies—simply depending on where the participant lives. And employer costs will skyrocket as plans absorb increased litigation expenses and pay for more expensive drugs and other benefits for which coverage was not contracted. Consumers will pay the ultimate price—co-payments and deductibles will increase and plan benefits will decrease or be eliminated—all due to expanding liability.

Clearly, *Davila's* narrow view of ERISA section 502 "stands as an obstacle to the accomplishment or the full purposes and objectives of Congress." *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99 (1993) (ERISA supersedes saved state insurance law applying traditional preemption principles). This Court should grant the petition and confirm that ERISA completely preempts state law remedies that supplement the remedies that ERISA provides for conduct that ERISA regulates.

B. The *Davila* decision mistakenly relies on the Court's "mixed eligibility" discussion in *Pegram* to deviate from the appropriate ERISA preemption analysis.

Prior to this Court's decision in *Pegram*, the circuit courts uniformly recognized that ERISA sections 514 and 502 preempt state law claims, whether tort or contract, that challenge an ERISA plan's claims decision, including claims determinations based on plan provisions that limit coverage to medically necessary treatments or condition coverage on pre-certification. *E.g.*, *Hull v. Fallon*, 188 F.3d 939 (8th Cir. 1999); *Danca v. Private Health Care Sys.*, 185 F.3d 1 (1st Cir. 1999); *Jass v. Prudential Health Care Plans, Inc.*, 88 F.3d 1482, 1488-89 (7th Cir. 1996); *Cannon v. Group Health Servs. of Oklahoma*, 77 F.3d 1270 (10th Cir. 1996); *Tolton v.*

American Biodyne, 48 F.3d 937 (6th Cir. 1995); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992). The courts reached this conclusion based on the administrative nature of the claims decisions, recognizing that such decisions may involve medical judgment.

The Fifth Circuit mistakenly relied on *Pegram* for its conclusion that ERISA section 502 does not preempt Davila's tort claim. The Second Circuit and Eleventh Circuit have aligned themselves with the Fifth Circuit. *Cicio v. Does*, 321 F.3d 83 (2d Cir. 2003); *Land v. Cigna Healthcare of Florida*, ___ F.3d ___, No. 02-15549, 2003 WL 21751247 (11th Cir. July 30, 2003). But the Fourth Circuit and Third Circuit have rejected the temptation to revisit the teachings of *Pilot Life* in light of *Pegram*. *Marks v. Watters*, 322 F.3d 316 (4th Cir. 2003); *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001).

The holding in *Pegram* is straightforward: an HMO's treating physician does not act as an ERISA fiduciary when making a medical treatment decision. Not surprisingly, the Court also indicated its understanding that treating physicians who make inappropriate treatment decisions are subject to state malpractice suits. *Id.* at 236. Indeed, that occurred in *Pegram* where the treating physician was found liable for malpractice under Illinois law. *Id.* at 217-18.

Pegram, however, includes dicta which characterizes the physician's decision as a "mixed eligibility decision"—a decision with both eligibility and treatment components—which may be redressed by a suit under state law. This "mixed eligibility decision" discussion has been improperly construed in *Davila*, *Cicio* and *Land* to signal this Court's intent to expose a claims administrator—who is not acting in a direct treatment capacity—to state law claims whenever the claim arguably involves some form of medical judgment.

A closer read of *Pegram* reveals that the key inquiry is whether the person acts as a fiduciary in making the decision that is the subject of the complaint. *Id.* at 224-36. In *Pegram*, the Court judged that Congress did not intend for ERISA's strict duty of loyalty and prohibitions on conflicts of interest to displace state law in regulating physician conduct and compensation arrangements. As such, the treating physician in *Pegram* did not act as an ERISA fiduciary, and was subject to state law. In contrast, Aetna acted purely as a claims administrator and plan fiduciary and was subject to ERISA's regulation and exclusive remedies.

This Court should grant the petition to make clear what seems obvious—the *Pegram* Court was analyzing a treating physician making a *direct treatment decision* with respect to a patient. The Court was not analyzing the action of an ERISA fiduciary acting in an administrative capacity. And the *Pegram* Court had "no occasion" to address the scope of preemption under ERISA sections 514 and 502 with respect to such claims decisions even when such decisions are alleged to involve some medical judgment. *Id.* at 229, n.9. But *Davila* reflects the Fifth Circuit's judgment that *Pegram* overrules *Pilot Life* and *Taylor*. Instead, the Fifth Circuit should have followed the settled principle that the Court does "not normally overturn, or so dramatically limit, earlier authority *sub silentio*." *See Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 3 (2000).

II. THE DECISION TO MODIFY ERISA'S EXCLUSIVE REMEDY SCHEME IS PROPERLY LEFT IN THE HANDS OF CONGRESS, WHICH HAS ACTIVELY CONSIDERED THE MATTER FOR MORE THAN A DECADE AND, TO DATE, HAS CHOSEN NOT TO ACT.

The Court has repeatedly emphasized that ERISA is a "'comprehensive and reticulated statute,' the product of a decade of congressional study of the Nation's private

employee benefit system." *Great-West Life and Annuity Ins. Co. v. Knudson*, 534 U.S. 2004 (2002) (quoting *Mertens v. Hewitt Assoc.*, 508 U.S. 248, 251 (1993) and *Nachman v. Pension Ben. Guar. Corp.*, 446 U.S. 359, 361 (1980)). The Court therefore has been "reluctant to tamper with an enforcement scheme crafted with such evident care. . . ." *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985).

The Court's respect for congressional policy choices is evident in its determination that ERISA's remedies are exclusive:

> [T]he detailed provisions of § 502 set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.

Pilot Life, 481 U.S. at 54.

Congress fully understands that ERISA's remedies are exclusive. Informed by *Pilot Life*, for more than a decade Congress has debated whether to lift ERISA preemption to permit state law suits, add a new damages remedy directly to ERISA, or leave existing remedies intact.[6] But unlike the decade of study that led to ERISA, no congressional consensus has emerged.

[6] Early consideration occurred in 1991 when Representative Berman (D-CA) and Senator Metzenbaum (D-OH) sought to amend ERISA section 514 to allow state law claims against insurers to address the Court's decision in *Pilot Life*. *See* Health Insurance Claims Fairness Act of 1992, H.R. 1602, 102d Cong. (1991); S. 794, 102d Cong. (1991).

Recent legislative consideration occurred from 1998 through 2001 when the House of Representatives and the Senate passed a number of Patients' Bill of Rights acts with very different remedy provisions.[7] For example, the most recent Senate-passed measure, S. 1052, endorsed a complex scheme of state and federal remedies. Under the Senate approach, ERISA would not preempt state lawsuits where a claims decision involved some form of medical judgment. *See* S. 1052, § 402(b) (amending ERISA section 514). In addition, a new federal remedy under ERISA would be established for claims denials that did not involve medical judgments with unlimited compensatory damages and a $5 million limit on punitive ("statutory") damages. *See* S. 1052, § 402(a) (amending ERISA section 502). In contrast, the most recent House-passed measure adopted added exclusively federal remedies, with limits on both compensatory and punitive damages, and affirmed that state law claims involving claims determinations are preempted. *See* H.R. 2563, § 402(a).

This past year, Congress has chosen not to act on similar legislation. But this too reflects a policy choice—a decision not to add costly new damages remedies against ERISA health plans at a time of spiraling health care premiums and costs. *See* Barbara Martinez, *Health Benefits Post Highest Gain Since '90*, WALL ST. J., Dec. 9, 2002, at A6 (health care costs expected to rise by 14% in 2003).

This Court should grant the petition so that the contours of ERISA's remedy scheme remains entrusted to Congress. The Court has recognized many times that courts are ill-suited to make the types of sweeping policy decisions Congress must

[7] *See* Bipartisan Patient Protection Act, H.R. 2563, 107th Cong. (2001); Bipartisan Patient Protection Act, S. 1052, 107th Cong. (2001); Bipartisan Consensus Managed Care Improvement Act, H.R. 2990, 106th Cong. (1999); Patients' Bill of Rights Act, S. 1344, 106th Cong. (1999); Patient Protection Act, H.R. 4250, 105th Cong. (1998).

routinely make. *See, e.g., Tennessee Valley Auth. v. Hill*, 437 U.S. 153, 195 (1978). Indeed, the *Pegram* decision itself recognized that Congress alone must expand or retract the reach of ERISA. *Pegram*, 530 U.S. at 234. Instead of following this teaching of *Pegram*, the lower courts in *Davila*, as well as *Cicio* and *Land*, have grasped at the Court's dicta in *Pegram* and rushed to make the types of policy decisions that Congress alone is suited to make.

CONCLUSION

The petition for writ of certiorari should be granted.

Respectfully submitted,

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